Eligibility Churning, Continuity of Coverage and Care: Data and Issues

Washingtonians' income levels, as a percent of poverty, fluctuate due to job and family size changes. As a result, their eligibility for Medicaid, Exchange or employer coverage will also change. That is:

- Some initial Exchange enrollees will become Medicaid eligible for a while, then return to the Exchange as their income fluctuates over time.
- Similarly, some initial Medicaid enrollees will move to the Exchange for a while, and then return to Medicaid.

Reasons for Concern:

Where Medicaid health plans and providers differ from Exchange or from employer coverage, significant problems from such "churning" include:

- discontinuity of provider relationships and care, with associated quality and cost problems, including the undermining of medical homes;
- distress, inconvenience, confusion (compromising access) for enrollees/patients;
- administrative expense for plans;
- incentives/cost-effectiveness for plans and providers to invest in longer-term health improvements negated.
- Affordability of coverage for some tax-credit eligibles, particularly for poor persons with depleted resources whose current incomes increase (and related selection concerns).

Such income churning will be particularly acute for people whose income (eligibility status) fluctuates between the Exchange and Medicaid over time. People who cross the 139% FPL threshold from one year to the next are about 3 times as likely to go back to their original income range in the third year, compared to the likelihood that people who stayed in the same income range for the first two years will cross the threshold in the third year.

Data Insights: [Data are for US adults (19-64, without employer coverage at a defined point during the middle year).]

The attached data from the same 3-year longitudinal household survey show the scope and shape of this dynamic.

TABLE 1

Actual Annual Income for Enrollment Year v. Income at Initial Determination
NO ESI at Initial Determination
Adults Age 19-64, UNITED STATES

Row Percent	[- Final FPL Range -]			
Initial FPL Range	**<139% FPL**	**139%-400% FPL**	**>400% FPL**	**TOTAL**
<139% FPL	73.6%	21.1%	5.3%	100.0%
139%-400% FPL	23.9%	63.1%	13.0%	100.0%
>400% FPL	10.3%	38.5%	51.3%	100.0%
TOTAL	51.5%	35.7%	12.9%	100.0%

Initial FPL Range	**<139% FPL**	**139%-200% FPL**	**201%-400% FPL**	**>400% FPL**	**TOTAL**
<200% FPL	68.3%	12.5%	13.8%	5.3%	100.0%
139%-200% FPL	38.1%	24.0%	32.4%	5.5%	100.0%
201%-400% FPL	16.6%	15.9%	50.6%	16.9%	100.0%

Notes:

FPL = federal poverty level.

Source:

Tabulations of the Survey of Income and Program Participation by John A. Graves, Ph.D., Vanderbilt University School of Medicine, with computing support and consultation from Jonathan Gruber, Ph.D., Professor of Economics at MIT.

Eligibility Churning, Continuity of Coverage and Care: Policy Options

Potential Policy Options to Address Plan and Provider Discontinuity due to Churning

Exchange-to-Medicaid Continuity

Require or allow Exchange QHPs to participate (with the same QHP provider network) in Medicaid on (at least) a limited basis to provide continuing coverage to their commercial QHP enrollees who move to Medicaid.

Considerations

While Medicaid capitation rates will be considerably less than QHPs' Exchange premiums, reduced churning should lead to some reduced costs for plans in the form of:

- administrative savings;
- reductions in redundant testing, inconsistent or incompatible care regimes, scrips, etc.;
- reductions in service use per month due to improved early intervention and care management, etc. *(i.e., for patients who would otherwise leave the plan and associated care management for a period of time and return in a deteriorated condition and/or with pent-up care needs).*

Is it realistic to expect some savings?

Possible Measures to Limit/Reduce the Cost Impact on QHPs That Provide Continuity for Enrollees Moving to Medicaid

(1) Put time limits on the duration of such coverage continuation under Medicaid. *Ideally, the duration would accommodate a significant share of individuals whose income is only temporarily reduced and will return to Exchange eligibility shortly.*

(2) Limit this continuity option to those who meet a minimum (pre-Medicaid) QHP enrollment duration, e.g., only those who had already been enrolled in the QHP for 3 or more months would have the option.

(3) Put pro-rata limits on Medicaid enrollment obligations to limit disproportionate burdens on any given QHP. (For example, no plan would be obligated to extend continuing Medicaid coverage to a population that exceeds some percentage, e.g., 5% or 10%, of their Exchange enrollment.)

(4) Put limits on qualifying income levels. (For example, constrain to expansion populations with incomes above 75% FPL, whose Medicaid benefits might be most similar to those of Exchange QHPs.)

(5) Other cost-limiting ideas?

Possible Measures to Compensate QHPs for losses

Alternatives might include an adjuster across (a) Exchange QHPs, (b) the total individual market, or (c) the individual and group markets combined.

Provide 12-Month Continuous Eligibility / Guaranteed Enrollment for (non-ABD) Adult Medicaid Enrollees

Adults (19-64) who are determined eligible for Medicaid (based on current income) would be guaranteed enrollment for a full 12 months, regardless of any subsequent changes during that period in their income or family composition. (No parallel provision with respect to continuous eligibility for Exchange coverage is considered, because neither the Exchange nor the State has the authority to diverge from federal rules in this regard.)